STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| (Continued)<br>18. Hospice Care | 6. When a participant revokes the election of hospice care during an extended election period, further Program coverage of hospice care shall be forfeited.<br><br>7. A participant may designate a new provider of hospice care no more than once during an election period.<br><br>8. When a recipient is enrolled in Medicare Part A. Program payment for hospice care shall be limited to payment for the Medicare hospice care coinsurance amounts for drugs and biologicals and for respite care and, where applicable, room and board for residents of an intermediate care facility or skilled nursing facility.<br><br>9. Billing time limitations:<br><br>a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.<br><br>b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:<br><br>(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and<br><br>(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later. |

2a Pg 9-2

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STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| (Continued)<br>18. Hospice Care<br><br>See Page 9-2 | c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.<br><br>d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.<br><br>e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined. |

STATE PLAN MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| 20. a. Pregnancy-related and postpartum services for 60 days after pregnancy ends. | Any covered medicaid service that is required during the 60 days after pregnancy ends, that is pregnancy-related or postpartum-related, will be provided. |
| b. Services for any other medical conditions that may complicate pregnancy | Any covered medicaid service that is required for medical conditions that may complicate pregnancy will be provided. |

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| 23. Any other medical care type of remedial care recognized by the Secretary | |
| a. Transportation | |
| 1. Ambulance Services (COMAR 10.09.13) | 1. This Program does not cover any payment for services other than coinsurance and deductible as approved by Medicare.<br>2. Billing Time Limitations - See page 9-2. |
| 2. Transportation Grants (COMAR 10.09.19) | 1. This Program is funded as an administrative expense.<br>2. Monies from a grant provided under these regulations may n be used to pay for the following:<br>A. Emergency transportation services;<br>B. Medicare ambulance services;<br>C. Transportation to or from Veterans Administration hospitals unless it is to receive treatment for a non-military-related condition;<br>D. Transportation to or from any correctional institution<br>E. Transportation of recipients committed by the courts mental institutions;<br>F. Transportation between a nursing facility and a hospi for routine diagnostic tests, nursing services, or physi therapy which can be performed at the nursing facility<br>G. Transportation services from a facility for treatment when the treatment is provided by the facility in whic the recipient is located;<br>H. Transportation to receive nonmedical services; |

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STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| (continued)<br>23. Any other medical care type of remedial care recognized by the Secretary<br><br>a. Transportation<br><br>2. Transportation Grants (COMAR 10.09.19) | I. Gratuities of any kind;<br>J. Transportation between a medical day care facility and the recipient's home;<br>K. Transportation to or from a State facility while the patient is a resident of that facility;<br>L. Transportation of non-Medical Assistance recipients;<br>M. Trips for purposes related to education, recreational activities, or employment;<br>N. Transportation of anyone other than the recipient, except for an attendant accompanying a minor or when an attendant is medically necessary;<br>O. Wheelchair van service for ambulatory recipients;<br>P. Ambulance service for a recipient who does not need to be transported on a stretcher;<br>Q. Transportation between a Community Rehabilitation Program (CRP) and the recipient's home;<br>R. Transportation between a Day Rehabilitation Program and the recipient's home;<br>S. Transportation to or from services that are not medical necessary. |
| 3. Transportation Services Under The Individuals With Disabilities Education Act (IDEA) (COMAR 10.09.25) | 1. Only providers who are local education agencies, local lead agencies, state-operated education agencies, or state-supported education agencies may participate.<br><br>2. Providers shall only bill the program for transportation service on dates when other Medicaid covered services are provided.<br><br>3. Billing Time Limitations - See page 9-2. |
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STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| (continued)<br>23. Any other medical care type of remedial care recognized by the Secretary<br><br>a. Transportation<br><br>4. Emergency Service Transporters (COMAR 10.09.31) | 1. Under this chapter, the Program does not cover services:<br><br>A. Not in response to a "911"call;<br>B. Performed by an emergency service transporter that is not enrolled with the Program;<br>C. To anyone other than an eligible recipient; and<br>D. For which proper documentation, including but not limited to run sheets, cannot be provided on request of the Department or its designee.<br><br>2. Billing Time Limitations - See page 9-2. |

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| 23. d. Skilled nursing facility services for patients under 21 years of age. | 1. No special allowance for private room rates.<br><br>2. Billing time limitations:<br><br>a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.<br><br>b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:<br><br>(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and<br><br>(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.<br><br>c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.<br><br>d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.<br><br>e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined. |
| Services that Require Preauthorization | 1. All admissions as to medical necessity and level of care. |

See Page 9-2

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STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| 23. e. Emergency Hospital Serv. | 1. Billing time limitations:<br><br>a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.<br><br>b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:<br><br>(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and<br><br>(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.<br><br>c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.<br><br>d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.<br><br>e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined. |

See Page 9-2

No. 91-16
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STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| Services that require preauthorization | None required |
| 23. f. Personal Care services in recipient's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N. | The following are not covered:<br>1. Skilled services performed by persons with profes training;<br>2. Services primarily for the purpose of housekeepir<br>3. Meals delivered to the home;<br>4. Services provided by family members;<br>5. Expenses incurred by personal care providers wh escorting recipients to obtain medical diagnosis or treatment; |

STATE PLAN FOR MEDICAL ASSISTANCE
UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF MARYLAND

| PROGRAM | LIMITATIONS |
|---|---|
| (Continued)<br>23. f. Personal Care services in recipient's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under the supervision of a R.N. | 6. Billing time limitations:<br><br>a. The Department may not reimburse the claims received by the Program for payment more than 6 months after the date of service.<br><br>b. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:<br><br>(i) Approved, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and<br><br>(ii) Denied, requests for reimbursement shall be submitted and received by the Program within 6 months of the date of service or 60 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.<br><br>c. A claim for services provided on different dates and submitted on a single form shall be paid only if it is received by the Program within 6 months of the earliest date of service.<br><br>d. A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original 6 month period, or within 60 days of rejection, whichever is later.<br><br>e. Claims submitted after the time limitations because of a retroactive eligibility determination shall be considered for payment if received by the Program within 6 months of the date on which eligibility was determined. |

See Page 9-2